Indiana J-1 Visa Waiver Program
The Indiana State Department of Health

Application Cover Sheet

Personal Information

Name of Applicant: _____
First Middle Last

Country of Origin _____ Area of Expertise _____

DOB: _____ Please circle one: MD DO

Address of Applicant: _____
Street

_____
City State Zip Code

Phone Number: _____ Fax Number: _____

Email: _____ Pager Number (optional)_____

Case Review Number:_____ IN Medical License Number_____

Attorney Information

Attorney/Firm Representing the Applicant: _____

Address: _____
Street City State Zip

Phone: _____ Fax: _____

Email: _____

Facility Information

Employer: _____

Employer's Contact Person _____
Name Title

Address: (Include the County): _____
Street

_____
City County State Zip

Phone: _____ Fax: _____

Email: _____

Practice Site Address (if different)

_____
Street City County State Zip

Phone: _____ Fax: _____ Email:_____

HPSA ID #_____ MUA/MUP ID# _____

Census Tract # _____ FIPS County Code _____
_____

Type of Facility: • Hospital_____ • Safety Net Provider_____

- Federally Qualified Health Center/Look Alike _____
- State funded Community Health Center _____
- Rural Health Clinic (not for profit only) _____
- Other _____
- Indiana State Department of Health Funded Facility_____

If there are multiple sites, provide all information for each site on a separate sheet.